CPI *Unrestrained* Transcription

Episode 42: De-Escalation Tales

Record Date: July 5, 2017

Length: 26:17

Host: Terry Vittone

Voiceover: Welcome to *Unrestrained*, the podcast series from CPI. Here you can enjoy conversations where professionals on all sides of crisis and behavior management relax and open up about themselves, their workplace, and their clients. You'll get the latest tips and trends from the best in the business, so tune in often to integrate their experiences with your own.

Terry: Hello, and welcome to *Unrestrained*, the CPI podcast series. This is your host, Terry Vittone. This month's episode of *Unrestrained* is unique in the history of the series. Rather than presenting a one-on-one interview with an expert in crisis or behavior management, it instead tells the backstory and includes several examples of *De-Escalation Tales*, a series of informative, convenient, short stories (five minutes or less) told by CPI Certified Instructors about their real-life experiences successfully de-escalating challenging, disruptive, or dangerous behaviors in their workplaces. Along with the examples included in the podcast, this series of audio recordings is presented in CPI's Yammer Instructor Community, a platform available to all CPI Certified Instructors. To learn how to access the Community, see the "How to access the Yammer Instructor Community" section of the article accompanying this recording.

In early 2014, I was new to CPI and tasked with producing copy and content relevant to our training. One of my first initiatives was to conduct an interview with architect Amy Schoenemann, the director of design development for PDC Midwest, a Wisconsin-based, architect-led design-build firm that specializes in senior living. Amy granted us an informative and inspiring interview about how physical environments are critical components of successful memory care programs. The interview, relevant to our Dementia Care Specialists offering, is available in print only. You can find it by typing "PDC Midwest" in the search bar of the blog section of CPI's website.

Because of the interest generated by Amy's interview, our internet marketing manager suggested CPI begin a podcast series, and *Unrestrained* was born. Soon after, I was given the opportunity to take the four-day Instructor Certification Program option of CPI's *Nonviolent Crisis Intervention*® training. The course was a revelation for me. From the introduction of CPI's *Crisis Development Model*℠, the

behavioral model that begins the training, through the Postvention strategies at its conclusion, I knew that the content in *Nonviolent Crisis Intervention*® training was revolutionizing the way I would approach, interpret, and react to challenging behavior in the future.

I remember thinking that the special education, health care, and human service professionals who took the course along with me were feeling the same sense of enlightenment. I was taken by their thoughtful questions and the way they related CPI concepts and techniques to the behavioral challenges that they experienced back on the job. Through their engagement, it was evident that the course material was deeply utilitarian and immediately relevant. I could feel their excitement about, and embrace of, the material as the training progressed, and I felt a rush of appreciation for how the lives of the people they taught, treated, and worked beside would be positively impacted.

After the training, we began producing monthly episodes of *Unrestrained*, and some of the best components of these full-length interviews are the real-life stories of de-escalation recounted by our interview subjects. After more than a year of podcast production, I wondered how we could get more of these real-life scenarios.

Taking a cue from the success of storytelling programs such as NPR's StoryCorps and The Moth Radio Hour, CPI decided to launch the storytelling series *De-Escalation Tales* in the company's Yammer Instructor Community platform. The five De-Escalation Tales that follow are representative of the series and illustrate how different aspects of CPI training can help provide safer, least restrictive environments and optimal outcomes for individuals exhibiting challenging or crisis behavior. I hope you enjoy them. Thank you.

Voiceover: You're listening to *De-Escalation Tales*, where Certified Instructors share their experiences working through challenging situations.

Mahdee: My name is Mahdee Raiees Dana, and I am an administrator for an immediate care facility and work with Pathfinder, Inc. And my story is about a young lady that is bipolar, who was basically traveling down the slope of her depressive stage, and had been promised to go on a home visit with her mother. But she got into some problem and trouble [when] her mother basically cancelled the visit. And she got pretty upset because of the cancellation, and had grabbed a large knife, and was in her bedroom yelling, screaming, saying things like, "She lied to me. How can she do this to me? She hates me!," you know, things like that. And she was threatening to kill herself with the knife.

At this point, she was pretty much at the Release stage of the *Verbal Escalation Continuum*℠, and within a short period of time, it became obvious to me that she

was kind of coming down from that adrenaline peak of her rage. You know, her face was red; her lips had dried up; and her saliva had turned into like, a fine foam, and she wasn't yelling as loud as she was. So you know, my thinking was that she's dehydrated, she's tired, she's out of energy. So I basically told her, you know, "You can do that later. I'm going to go get some ice cream. Do you want some?" And she kind of looked confused for several seconds and just dropped the knife on the bed and followed me to the kitchen where we just kind of sat down and talked about her situation over ice cream.

You know, in CPI physical intervention, when somebody grabs you, there are some physical and psychological advantages that you can use to get out of that grab. And this person, she had a—you know, when somebody grabs you, you also use this psychological advantage by using the element of surprise. And she basically had this grab, a mental grab on this situation, and obsessing, and wanting to kill herself, and I had to use that element of surprise to break her concentration. And it did work this time, but you know, the majority of time it is the personal response to the intervention that will make it successful or not. So that was my story.

Voiceover: Welcome to *De-Escalation Tales*. Our story today comes from Victoria Kim, a Certified Instructor and social worker at Gages Lake School in the Special Education District of Lake County, Illinois. Victoria shares a story about how a *Supportive Stance*℠, patience, and redirection combine to accomplish a successful intervention.

Victoria: Hi. My name is Victoria Kim. I'm a school social worker at Gages Lake School. I've been a CPI Instructor for the past five years.

I would like to tell you about Becca. Becca is an aide within our program, within our organization. I currently work for the Special Education District of Lake County, so we service a whole range of special-needs students. So the class that she worked in in particular was a class for students with autism. So in our school, we had that class and then we also had class for students with severe behavior and emotional needs.

So in the morning when the students come off the bus, they come in through this sort of a cul-de-sac. And you know, as the buses come through, the kids can walk toward the school or there's kind of two lanes of bus traffic coming in. So we had a student that came off the bus, one of the students with autism, and it's fairly severe autism. And when he got off the bus, he was very escalated. He came off flapping, and he began to run toward the two lines of traffic moving. And you know, he's a small student. I didn't know if they could see him around the buses. I was able to put out my arms to kind of maneuver him away from that area. And he kind of settled into a grassy spot in between the buses and the school, threw down

his bag, was pacing, was flapping, rocking, really showing, you know, a lot of anxieties, but also a lot of concern about, "Is there risk behavior there as well?"

So Becca, his aide, approached him, and the first thing she did is she stopped about six feet away from him and smiled at him, and said, "Good morning," and she just waited for him. And when he didn't respond, she put up a little—she has this note card that has pictures of directions on it, and you know, she held up one that said "Walk." And she held it up, and she put out her hand, and she waited, and she waited probably a good minute before the student came in, which was perfect because, you know, there are processing issues, and in particular when he's upset, they're even more significant processing issues. And he walked in the building. He took her hand; he walked in gently. And it really, I think, was a beautiful intervention on many levels.

Initially, the student got off the bus demonstrating some significant risk behavior. We could have done a restraint at that time as he's running out into traffic. There's, of course, a lot of concerns with that. You know, we don't want to put our hands on students if we don't need to. There's risk of harm to him, harm to us, but there's also all of these students getting off the bus, so you have 150 students getting off the bus at that time. You know, you have the bus drivers; you have parents. You know, it's not a good situation in general. Plus, if that behavior escalates from there, it's not necessarily the best, most safe place to be.

So you know, I really loved that we were able to kind of hold up our arms and direct him, without touching him, into an area where he was safer. And although he was still escalated, you know, he wasn't moving from the area. He was staying stationary, you know, really showing some signs of anxiety, and she started with support of, "Good morning." And then, you know, she moved into her defensive—I'm sorry, into her directive with her card, and he responded. You know, each time he kind of came down a little, and I liked that she just did that very naturally.

And I was so impressed with it I wrote a letter to her supervisor, you know, to put in her staff file. You know, it was just a brilliant intervention that she just did naturally.

Voiceover: Welcome to *De-Escalation Tales*. Our story today comes from James Gulbranson, a security supervisor and *Nonviolent Crisis Intervention*® and *Prepare Training*® Certified Instructor with Minnesota's CentraCare Health System. James shares a story that illustrates the importance of a team leader, team utilization, appropriate verbal escalation response, and the use of the least restrictive physical intervention as a last resort in successfully de-escalating an agitated patient.

James: Hello. My name is James Gulbranson. I'm a security supervisor, and NCI [*Nonviolent Crisis Intervention*® training] and PTP [*Prepare Training*®] Instructor with

CentraCare Health. I think the story I'm going to talk about today kind of shows how in many incidents, a variety of *Nonviolent Crisis Intervention*® concepts can and should be utilized. The example I'm going to talk about touches on some of the key concepts, like utilizing your team, the importance of a team leader, appropriate verbal escalation response, and using the least restrictive physical intervention as a last resort.

My De-Escalation Tale takes place at one of our critical access hospitals. This incident occurred on a medical surgical inpatient unit with a patient that had been there for about four days. This patient was in his early 70s and had medical needs as well as geriatric psych needs.

Since his arrival on the unit, his risk behavior had increased daily, primarily due to him not always knowing where he was, and trying to leave his room or going to other patients' rooms. Early on, he'd been placed on a one-to-one due to this behavior, and also him being a fall risk if he walked on his own.

Something we initiated early to help manage this [behavior], the desire to leave his room and the building, [was] with the assistance of staff, he was allowed to leave his room and walk a few laps around the unit, whenever he asked. Again, we tried to find some good way to respond to potentially challenging behavior, trying to find some of his triggers, and try to find a safe outlet for them.

On this day in question, I was called to the main desk of this medical surgical unit, and arrived and found the patient and his one-to-one were standing in the common area. The patient was pretty upset; he wanted to leave the building. Myself and the one-to-one staff had a pretty good rapport with him since we had worked with him quite a bit. After we spoke to him and he remembered he was in the hospital, he requested just to be able to walk around a little bit with the staff member. So I stood by on the unit while staff did this walk-around with him, wanting to make sure he would return and his behavior didn't escalate.

After a short time, I was flagged down to go around the corner, where they had walked, to assist. Upon my arrival around the corner, I found the patient standing near a window, yelling and swinging his cane past the staff member, the one-to-one, [she was] trying to use her, you know, positioning behind him, holding his belt up to kind of keep him standing, but also to be in a safe place. The patient was threatening to smash out the window he was next to, to try to escape. He was also threatening to strike any staff member who got near him.

I slowly approached him, a way to tell [when] he was kind of looking away. And I took hold of his cane above and below where he was holding it, and stabilized it. Shortly thereafter, an RN and a social worker who's actually worked with this patient arrived to assist. I directed the RN to close the adjacent patient rooms and

clear some other people out of the area, and asked the social worker to grab a wheelchair for this individual since he was standing and was a fall risk.

We got the wheelchair; we got the patient seated in the wheelchair, and he continued to shout and threaten us with his cane. I continued just to hold and stabilize the cane, giving him verbal directions, again, at this point, really utilizing that idea of relaxing and downplaying the situation. And I probably held onto the cane for about a minute before he eventually decided to let go of it on his own.

At that point, the patient was pretty upset with myself and the one-to-one. He wasn't really—we didn't have a good rapport with him. So the social worker kind of stepped into that team leader role and started talking with him, planning their care plan, kind of letting him know what was gonna happen next, and ended up eventually getting the patient to calm down. We got him back to his room from down the hall without any further issue or injury to the patient or the staff.

Again, I think, just thinking about this story itself, you can kind of see how important some of those concepts are: of utilizing a team, getting other people involved, especially with that team leader—finding a person who has good rapport with the person that's acting out, or [exhibiting] risk behavior, because that really went a long way in de-escalating this [situation].

The other part, I think, that was important was really utilizing the least restrictive physical intervention, because we did have a patient who was, through some relatively high-risk behavior, a fall risk, he had a weapon, he was threatening staff, he was threatening to damage property, he was threatening to do some things that could hurt himself, but at the same time, utilizing the least amount of force necessary.

When he was seated in the wheelchair and I had a hold of his cane, while he was yelling and screaming and trying to hurt us, he really couldn't follow through on any of that as long as I held onto the cane. So there was really no need to do anything additionally by twisting the cane or trying to pry his fingers, or do anything else. We could just calmly wait there ‘till we got him calm and he could let go on his own, you know, limiting the force we really needed to use. So that's my De-Escalation Tale.

Voiceover: Our De-Escalation Tale comes from Albertus Kral, the executive director of Ontario's Little House Residential Care Services, an organization that provides a home for children who can't live with their families. In this De-Escalation Tale, Albertus tells the story of how he reassured a nine-year-old boy who's fearful, anxious body language told a very different story than his words. As Albert says, “The words are one thing, but what are they really telling us?”

Albertus: Hello. I'm Albert, Albertus Kral of Little House Residential Care Services in Ontario, Canada, and I am the executive director. I have worked with children, and before I became the executive director, I was a house parent and we had six children in our home. I always have been interested and pay a lot of attention to the underlying messages that people say, and that also children say when they talk to us, when they communicate.

One day, because, many times, we have referrals, we got a child. He was about nine years old when he came to our organization. The routine is that we talk with them and they have the intake, and then we set up a session with a counselor to get a better read on the needs that he has.

So after two days, I got in the car with him and I drove him to the counselor, which is about a 40-minute drive. And while driving, he was sitting beside me in the front seat, the passenger seat, and suddenly he said, "Dad," and we are parents and children sometimes, at their own speed, they call us "mom" and "dad," or call us by the first name. But he adapted to that very quickly and said, "Dad?" I said, "Yeah?" He said, "The lady likes me." I said, "Yeah." It was quiet for a moment, and he said, "I'm gonna like the lady, too." I said, "Yeah, sure." And he was quiet and I looked beside me, and he was wringing his hands, eyes big. He said, "She will be a very nice lady." I said, "Yeah, she is." And I was thinking—I thought, "There's something more to this story. What is he really telling me?"

So I tell him—I said, "You know where you're going?" He said, "Yeah, to the lady." I said, "You remember we talked about it, you go to counseling. A lady talks with you about it and you talk to her about how you feel, and a lot of other things." I said, "And you know what?" I said, "I'll be there." And he looked at me, I said, "You're gonna come back home with me." He said, "I do?" I said, "Sure, you do." I said, "What did you think?" He said, "Lady is gonna take me." I said, "No, no." I said, "We're gonna go back to Mom." I said, "We're gonna have supper." And his face changed, and he had a smile on his face.

And the story of this is that what he told me was that he had had about eight or nine different placements within a year, year and a half. So what they did, for whatever reason—and I'm not qualifying the reason whether they are good or bad, but they didn't inform him. So a social worker came and they took him out of the home and then they placed him in another home. So with that, he thought that I would do the same thing, and it brought on a lot of anxiety to the point that when we were driving, his hands were so wet they were dripping from sweat. And I'm not kidding. He was one of the children where his anxiety was so great.

So what we did, I reassured him over and over again. And even when he was home, and we had to go somewhere, we will tell him where he would go and we will then say, "But you're gonna come back home," and it took quite a while before that

anxiety really was reduced, and eventually he knew that he would come back. So, I am an advocate of listening to the underlying factors for they are extremely important. The words are one thing, but what are they really telling us? And when we know that, then we can be proactive. We can deal with that and just bypass the words.

So for anybody who listens and was interested in that, and you take the course, CPI is great on that. Every aspect of CPI is very important.

Thank you for listening. My pleasure to tell the story.

Voiceover: Our latest De-Escalation Tale comes from D.C. Foster, a behavioral health specialist at the Arizona State Hospital. In this De-Escalation Tale, D.C. describes two men pacing in the psych unit and cursing angrily to unseen others, one in the day room and one in the patient dorm area. The two areas are connected by a single doorway. Listen to the story to learn what happens when the two men accidentally meet at the doorway, which D.C. describes as an imperfect nexus leading to a perfect storm.

D.C.: My name is D.C. Foster. I'm here at the Arizona State Hospital. I'm the behavioral health intervention specialist here in Phoenix. I want to tell you a story about two patients who were walking and talking a lot by themselves, possibly directing their talk to what appeared to be an unseen individual or unseen others. They were in different ends of the units. One was in the patient dorm area hallway, the other was in the day room. Our day room is connected or the two areas are connected by a doorway.

As one was pacing at the day room, he was overheard verbalizing and saying and yelling and shouting obscenities and swear words, and stuff directed at nobody in particular. That was kind of a normal behavior for him. The other individual was down at the end of the hallway in the dorm area, and he was yelling and screaming, and also yelling obscenities directed at nobody.

One of the reasons the staff didn't interfere with this: we gave them an opportunity to vent by putting them in two different areas, and we thought they were non-dangerous and they weren't demonstrating any dangerous behaviors or any acting-out behaviors. This was normal for them, so there was no intervention. However, a little bit later, they met at the doorway, which is the only opening, and that bridges the two areas. It was kind of an imperfect nexus leading to a perfect storm.

At that point, their eyes met while continuing to talk and yell obscenities. And just like a scene out of the movie *Taxi Driver* with Robert De Niro, they started talking to one another, and saying, "You talking to me? Are you talking to me? You talking

to me? You talking to me?" That only fueled their rage, and they started to close ranks and began hurriedly walking towards one another for an eventual conflict.

Staff intervened and redirected each of them at that particular point. One of the reasons that staff did not intervene [earlier] is because the behavior was normal and they were considered no threat at that particular time, being in two different areas and allowed to vent, but these kinds of things can occur.

In the debriefing, one of the things we asked, that we touched upon, was their ability to distract the patients. Even if they're talking to themselves and unseen others, staff can intervene and say, "Do you need some help? Is there something I can do for you?" And then if they focus on the staff, you got them out of that moment where they're dysregulated and talking to themselves. That could have been the technique that we could have used. However, it wasn't done at that particular time. So the debriefing, we took that and we put it in their nursing care plans to interrupt that behavior. We find that to be more palatable, let's say, than putting hands on an individual.

They were fine after that. They also took some PRN medication and stuff, and then they continued to walk and pace, and we allowed that to continue and go on. There was no further problem with either of these individuals, just an opportunity we missed to distract them. And that was talked about, and again, placed in the progress chart.

Terry: Thank you for joining us today on *Unrestrained*. Tune in again soon for another interview with an expert in behavior management. Until then, this is your host Terry Vittone, hoping your intention is prevention.